

# Wisconsin Department of Safety and Professional Services

**Mail To:** P.O. Box 8935  
Madison, WI 53708-8935  
**FAX #:** (608) 261-7083  
**Phone #:** (608) 266-2112

1400 E. Washington Avenue  
Madison, WI 53703  
**E-Mail:** web@dsps.wi.gov  
**Website:** http://dsps.wi.gov

## DENTISTRY EXAMINING BOARD

### APPLICATION FOR DENTAL LICENSE

Under Wisconsin law, the Department must deny your application if you are liable for delinquent state taxes or child support (sec. 440.12, Stats.).

Your name and address are available to the public.

**PLEASE TYPE OR PRINT IN INK** ☐ Check box to withhold street address/PO Box number from lists of 10 or more credential holders (Wis. Stat. § 440.14)

Last Name	First Name	MI	Former / Maiden Name(s)
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Your Street Address (number, street, city, state, zip)

Mail To Address (if different)

Date of Birth ____ month ____ day ____ year	Daytime Telephone Number (____) _____ - _____
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Ethnic/gender status information is optional. **Sex:** ☐ M ☐ F **Ethnic:** ☐ White, not of Hispanic origin ☐ Black, not of Hispanic origin ☐ Hispanic ☐ American Indian or Alaskan ☐ Asian or Pacific Islander ☐ Other

Have you ever held a license/credential in the state of Wisconsin? \_\_\_\_ Yes \_\_\_\_ No (please indicate)  
If yes, provide your Wisconsin license/credential number. \_\_\_\_\_

**School Name:** \_\_\_\_\_

**School Address:** \_\_\_\_\_  
(City) (State)

**Date Diploma Granted:** \_\_\_\_\_  
month/day/year

**Degree:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_

**APPLICATION FEES** Please check applicable blank: (Make check payable to Department of Safety and Professional Services and attach to application).

\_\_\_\_ **Exam (CORE, CRDTS, NERB, WREB)**  
\$ 75.00 Initial Credential Fee  
\$ 75.00 State Law Exam  
**\$150.00 Total Fee Attached**

\_\_\_\_ **Endorsement of a State Board Exam or Regional Exam**  
\$123.00 Initial Credential Fee  
\$ 75.00 State Law Exam  
**\$198.00 Total Fee Attached**

**For Receipting Use Only**

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**APPLICATION IS NOT COMPLETE UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN RECEIVED:**

Regional Dental Testing Service Score Card(s)  
(Original pass & fail)

Copies of malpractice suit(s)

National Board Score Card(s) (Original pass & fail)

Fee(s) attached to this application

Social Security Form (Page 6 of 6 Form #512)

Letters from all State Boards where licensed (includes active and inactive licenses)

Certificate of Professional Education  
(Form #1471)

National Practitioner Data Bank Report (*Not required of new graduates*)

Current CPR/AED Certificate (signed and dated)

Wisconsin Statutes and Rules Examination (online examination)

**IS NAME ON ALL CREDENTIALS THE SAME? IF NOT, SUBMIT CERTIFIED COPY OF MARRIAGE CERTIFICATE, DIVORCE DECREE, ETC.**

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**HAVE YOU BEEN TESTED BY A REGIONAL DENTAL TESTING SERVICE?**

\_\_\_\_ YES \_\_\_\_ NO If yes, provide original score card(s) of certification/notification of passing/failing and date.

**HAVE YOU TAKEN AND PASSED THE NATIONAL BOARDS?**

\_\_\_\_ YES \_\_\_\_ NO If yes, submit original cards from National Boards

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**PRACTICE:** Account for all activities and practice starting from the date of graduation to the present time. **Must include professional and nonprofessional activities. ALL time and dates must be accounted for.** (Attach additional sheets, if necessary.)

<b><u>NAME OF EMPLOYER AND THE CAPACITY IN WHICH YOU ARE/WERE EMPLOYED</u></b>	<b><u>LOCATION OF EMPLOYMENT (LIST CITY and STATE)</u></b>	<b><u>DATES EMPLOYED (FROM-TO) MO and YR</u></b>	<b><u># OF HOURS PER WEEK</u></b>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

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**I AM CREDENTIALLED IN THE FOLLOWING STATES**

(Include **active** and **inactive** credentials):

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( ) **I AM NOT CREDENTIALLED IN ANY OTHER STATE(S).**

**YOU ARE REQUIRED TO HAVE EACH STATE BOARD IN WHICH YOU HAVE EVER BEEN CREDENTIALLED SUBMIT WRITTEN VERIFICATION(S) TO THE WISCONSIN DENTISTRY EXAMINING BOARD. THIS IS REQUIRED IN ORDER TO COMPLETE YOUR APPLICATION FOR LICENSURE.**

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**ANSWER THE FOLLOWING QUESTIONS:** (Attach additional sheets if necessary.)

	<u>YES</u>	<u>NO</u>
1. Have you ever surrendered, resigned, canceled or been denied a professional license or other credential in Wisconsin or any other jurisdiction? If yes, give details on an attached sheet, including the name of the profession and the agency.	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever failed to pass any state board examination, national board examination? If yes, give details on an attached sheet. (Original pass/fail cards required.)	<input type="checkbox"/>	<input type="checkbox"/>
3. Has any licensing or other credentialing agency ever taken any disciplinary action against you, including but not limited to, any warning, reprimand, suspension, probation, limitation, revocation? If yes, attach a sheet providing details about the action, including the name of the credentialing agency and date of action.	<input type="checkbox"/>	<input type="checkbox"/>
4. Is disciplinary action pending against you in any jurisdiction? If yes, attach a sheet providing details about pending action, including the name of the agency and status of action.	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any felony or misdemeanor charges pending against you? If yes, attach a sheet providing details about the pending charge, copy of the court documents and status of the charge. (Please do not give details on minor traffic charges, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been convicted of a misdemeanor or a felony? If yes, attach a sheet providing details about the crime, including date of conviction, penalty and a copy of the court documents. (Please do not give details on minor traffic convictions, but do include information relating to <u>Driving While Intoxicated</u> (DWI) charges.)	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you incarcerated, on probation or on parole for any conviction? If applicable, attach a sheet providing details including the terms of incarceration and a copy of a report from your probation or parole officer.	<input type="checkbox"/>	<input type="checkbox"/>
8. Have any suits or claims ever been filed against you as a result of professional services? If yes, submit a copy of the claim or suit and a copy of the final settlement or disposition.	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you failed to pass the Central Regional Dental Testing Service Clinical examination, or any other dental licensing examination? If yes, state which examination, and the date of the examination. (Original pass/fail cards required.)	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you registered or licensed in any other profession(s)? If yes, state what profession(s) and in what states(s).	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been credentialed under any other name(s)? If yes, state name(s) credentialed under.	<input type="checkbox"/>	<input type="checkbox"/>
12. Has the Drug Enforcement Administration ever withdrawn your DEA number or warned you, or have you been denied a DEA number? If yes, give details on an attached sheet.	<input type="checkbox"/>	<input type="checkbox"/>

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For the purposes of these questions, the following phrases or words have the following meanings:

"Ability to practice dentistry" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned dentistry judgments and to learn and keep abreast of dentistry developments; and
2. The ability to communicate those judgments and dental information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or **within the past two years.**

"Illegal use of controlled dangerous substances" means the use of controlled dangerous substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

- |  | <u>YES</u>               | <u>NO</u>                |
|--|--------------------------|--------------------------|
| 13. Do you have a medical condition which in any way impairs or limits your ability to practice dentistry with reasonable skill and safety? If yes, please explain.  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Does your use of chemical substance(s) in any way impair or limit your ability to practice dentistry with reasonable skill and safety? If yes, please explain.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice? If yes, please explain.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism? If yes, please explain.   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are you currently engaged in the illegal use of controlled dangerous substances?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> |

# Wisconsin Department of Safety and Professional Services

## CERTIFICATION OF LEGAL STATUS.

I declare under penalty of law that I am (check one):

\_\_\_\_\_ a citizen or national of the United States, or

\_\_\_\_\_ a qualified alien or nonimmigrant lawfully present in the United States who is eligible to receive this professional license or credential as defined in the Personal Responsibility and Work Opportunities Reconciliation Act of 1996, as codified in 8 U.S.C. §1601 et. seq. (PRWORA). For questions concerning PRWORA status, please contact the U.S. Citizenship and Immigration Services in the Department of Homeland Security at 1-800-375-5283 or online at <http://www.uscis.gov>.

## ALL APPLICANTS MUST COMPLETE THIS SECTION

### AFFIDAVIT OF APPLICANT

(Sign and date in the presence of a notary)

**I declare that I am the person referred to on this application and that all answers set forth are each and all strictly true in every respect. I understand that failure to provide requested information, making any materially false statement and/or giving any materially false information in connection with my application for a credential or for renewal or reinstatement of a credential may result in credential application processing delays; denial, revocation, suspension or limitation of my credential; or any combination thereof; or such other penalties as may be provided by law. I further understand that if I am issued a credential, or renewal or reinstatement thereof, failure to comply with the statutes and/or administrative code provisions of the licensing authority will be cause for disciplinary action.**

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

State of \_\_\_\_\_ County of \_\_\_\_\_

Subscribed and sworn to before this \_\_\_\_\_ day of

\_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_  
(Applicant name)

\_\_\_\_\_  
Signature of Notary Public

**S E A L**

\_\_\_\_\_  
Date Commission Expires

# Wisconsin Department of Safety and Professional Services

**SOCIAL SECURITY NUMBER.** Your social security number (or employer identification number if you are applying as a business entity) must be submitted with your application on this form. If you do not have a social security number you must submit a statement under oath or affirmation. If your social security number or a statement is not provided, your application will be denied.<sup>1</sup> A form for submitting a statement that you do not have a social security number is available from the department.

**(Please Print)**

<b>First Name</b>	<b>Middle Initial</b>	<b>Last Name</b>
<b>Profession</b>		
Date of Birth	<div style="border-bottom: 1px solid black; width: 100px; margin: 0 auto;"></div> <div style="text-align: center;">month</div>	<div style="border-bottom: 1px solid black; width: 100px; margin: 0 auto;"></div> <div style="text-align: center;">day</div>
		<div style="border-bottom: 1px solid black; width: 100px; margin: 0 auto;"></div> <div style="text-align: center;">year</div>
<div style="display: flex; align-items: center; justify-content: center; gap: 10px;"> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"> </div> <div style="font-size: 24px;">-</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"> </div> <div style="font-size: 24px;">-</div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"> </div> <div style="border: 1px solid black; width: 40px; height: 40px; display: flex; align-items: center; justify-content: center;"> </div> </div>		
<b>Social Security Number or FEIN</b>		

The Department may not disclose the social security number collected above except to the Department of Children and Families for purposes of administering the child and spousal support program,<sup>2</sup> to the Department of Revenue for the purpose of determining whether you are liable for delinquent taxes,<sup>3</sup> and to the federal Healthcare Integrity and Protection Data Bank for the purpose of reporting adverse actions against health care practitioners.<sup>4</sup>

**EMAIL ADDRESS:**

**Do you have an email address?** ☐ Yes ☐ No

**If yes**, this field is required to receive your application status electronically. Your email address must be clearly legible with the correct case sensitive information.

**EMAIL ADDRESS:** Submit your email address in the spaces provided below or attach a printer copy.

[illegible]

**If no**, your checklist will be sent by first class mail.

<sup>1</sup> Section 440.03 (11m), Wis. Stats.

<sup>2</sup> Sections 49.22, and 440.13, Wis. Stats.

<sup>3</sup> Section 440.12, Wis. Stats.

<sup>4</sup> Health Insurance Portability and Accountability Act (HIPAA) of 1996